Ohio Administrative Code

Rule 5160-28-13 Outpatient health facility (OHF) services.

Effective: July 1, 2022

(A) "Outpatient health facility (OHF)" has the same meaning as in section 5164.05 of the Revised Code.

(B) Conditions affecting medicaid participation.

(1) Unless otherwise noted, any stipulations or limitations specified in the Revised Code or in agency 5160 of the Administrative Code apply to services rendered by an OHF.

(2) No OHF may enroll simultaneously in medicaid as FQHC or RHC.

(C) OHF covered services and limitations.

(1) Each OHF provides the following preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services, which are collectively termed, "comprehensive primary health services":

(a) Covered services provided on-site:

(i) Medical services, which may be divided into three categories:

(A) Services rendered by a physician or podiatrist;

(B) Services rendered by a physician assistant or advanced practice registered nurse; or

(C) Services rendered by a registered nurse or licensed practical nurse acting independently under standing orders of a physician or advanced practice registered nurse, under specific instructions from a previous visit, or under supervision of a physician or advanced practice registered nurse who has no direct contact with the patient during a visit (e.g., administration of an immunization or injection, change of dressing, removal of sutures, dispensing of hormonal contraceptives if vital signs are taken

during the visit, follow-up evaluation and management after insertion of an intrauterine device);

(ii) Early and periodic screening, diagnostic, and treatment (EPSDT) services and other preventive health services, such as children's eye and ear examinations, perinatal services, well-child services, and pregnancy prevention or contraceptive management;

(iii) Obstetrical care services, including a prenatal risk assessment for every woman receiving prenatal services, and at-risk pregnancy services for every woman diagnosed at risk of premature birth or poor pregnancy outcome;

(iv) Diagnostic laboratory services;

(v) Diagnostic radiological services; and

(b) Covered services provided on-site or arranged for by the OHF:

(i) Transportation services; and

(ii) Emergency medical services.

(2) In addition, an OHF may provide the following services:

(a) Medical services other than comprehensive primary health services:

(i) Services provided by a doctor of medicine, a doctor of osteopathy, a doctor of podiatric medicine, a physician assistant, or an advanced practice registered nurse;

(ii) Services provided by a registered nurse or a licensed practical nurse, under supervision, that would be covered if they were rendered by a physician or an advanced practice registered nurse;

(iii) EPSDT services; and

(iv) Services for women who have been determined to be at risk of preterm birth or poor pregnancy

outcome;

(b) Dental services;

(c) Mental or behavioral health services provided by a clinical psychologist or a clinical social worker;

(d) Vision services provided by a licensed optometrist, optician, or ocularist;

(e) Speech and hearing services provided by an audiologist or speech pathologist;

(f) Physical medicine services provided by a physician, podiatrist, physical therapist, or mechanotherapist;

(g) Laboratory services;

(h) Radiology services; and

(i) Transportation services, excluding ambulance and wheelchair van services addressed in Chapter 5160-15 of the Administrative Code, needed to transport a patient to or from the OHF or between the OHF and other medicaid providers with which the OHF has referral arrangements.

(3) No separate payment is made for medical supplies and drugs dispensed during a visit.

(4) An OHF that is enrolled separately in medicaid as another type of provider may be paid on a fee-for-service basis under its non-OHF medicaid provider number for providing any of the following services or supplies:

(a) Take-home drugs identified in Chapter 5160-9 of the Administrative Code; or

(b) Durable medical equipment (DME) and supplies for take-home use identified in Chapter 5160-10 of the Administrative Code.

(5) Claims for services provided off-site under contract are submitted separately to the Ohio Department of Medicaid (ODM). The contractor may submit such claims if it has a current medicaid provider number.

(6) With the following exceptions, limits on OHF services are specified in the chapter of the Administrative Code that addresses the type of service:

(a) For medical services, payment may be made for a maximum of twenty-four office visits per year. Physician visits listed in rule 5160-4-06 of the Administrative Code do not count toward this limit.

(b) For vision care services, payment may be made for one vision examination in a twelve-month period for patients younger than twenty-one or older than fifty-nine. Payment may be made for one vision examination in a twenty-four-month period for patients older than twenty and younger than sixty. Corrective eyewear is covered only if it is provided by one of ODM's contracted vision laboratories.

(D) Submission of an OHF cost report.

(1) After its initial program year, each OFH submits a complete and adequate cost report by April first of each year for the preceding calendar year.

(a) "Cost report" is a report of costs submitted to ODM together with all schedules, attachments, and supporting documentation, in accordance with the instructions specified for the form.

(b) For an OHF, the form is the ODM 03421,"Federally Qualified Health Center / Outpatient Health Facility Cost Report" (rev. 04/2022).

(2) An OHF's provider agreement may be terminated in either of two circumstances:

(a) The OHF fails to submit a cost report by May first.

(b) The OHF submits an incomplete or inadequate cost report by April first and does not correct it within forty-five days of notification of deficiency.

(3) Government institutions operating on a cash basis may use the cash method of accounting. All other OHFs use the accrual method.

(E) Prospective payment system (PPS) method for determining OHF payment.

(1) An all-inclusive per-visit payment amount (PVPA) is established for each OHF service provided at an OHF service site

(a) For every OHF newly enrolled as a medicaid provider, ODM sets the PVPA for a service at the average PVPA for all participating OHFs.

(b) After the initial PVPAs are set, each OHF submits an annual cost report in accordance with this rule. New PVPAs are established on the basis of the cost report, to which an inflation factor is applied.

(i) The inflation factor is the sum of the following figures:

(A) The actual inflation rate between the midpoint of the cost report year and the midpoint of the following year as established by the United States bureau of labor statistics; and

(B) An estimated inflation rate from the midpoint of the preceding year to the midpoint of the year for which the PVPA is calculated based upon the preceding twelve-month average.

(ii) Unless otherwise specified, an inflation factor is computed from monthly statistical data supplied by the United States bureau of labor statistics for the following cost areas:

(A) Non-physician-level personnel costs (e.g., nurses, administration, legal staff, accounting, management, data services, employee fringe benefits, medical records, operation and maintenance services, housekeeping, laundry);

(B) Medical supplies countable as a separate expense;

(C) Non-durable goods (e.g., office supplies, printing);

(D) Fuel and utilities;

(E) Transportation services;

(F) Physician-level medical personnel and rehabilitation professionals;

(G) Insurance; and

(H) Real estate taxes.

(2) Audits.

(a) ODM or its designee may perform a desk review or conduct a field audit of any cost report submitted and may request any supporting documentation it deems necessary.

(b) Decisions of ODM with respect to the establishment or adjustment of a PVPA are not subject to Chapter119. of the Revised Code.

(F) Determination of a PVPA for an OHF service on the basis of a medicaid cost report.

(1) Separate PVPAs are established for the following services:

(a) Medical services;

(b) Dental services;

(c) Mental or behavioral health services provided by a clinical psychologist or a clinical social worker;

(d) Vision services provided by a licensed optometrist, optician, or ocularist;

(e) Speech and hearing services provided by an audiologist or speech pathologist;

(f) Physical medicine services;

(g) Laboratory services;

(h) Radiology services; and

(i) Transportation services.

(2) Allowable costs are calculated in accordance with the instructions for the OHF cost report. Certain restrictions apply

(a) Costs related to patient care are not allowable.

(b) Procedures or items that are not OHF services are not allowable.

(c) The straight-line method of computing depreciation is used for all depreciable assets.

(d) The cost claimed for services, facilities, and supplies furnished by a related organization does not exceed the lesser of two figures:

(i) The cost to the related organization; or

(ii) The price of comparable services, facilities, or supplies generally available.

(e) Total allowable administrative and general overhead costs do not exceed fifteen per cent of the costs of the services to which they are applied.

(3) Tests of reasonableness are applied to the allowable costs to establish limits.

(a) PVPAs established for any of the indicated services are not to exceed the lesser of two numbers:

(i) The quotient obtained by dividing the reported allowable cost by the reported number of visits; or

(ii) The quotient obtained by dividing the reported allowable cost by the product of the actual number of direct hours worked by the professional and the applicable number of encounters per hour from the following list:

(A) Medical services 2.4;

(B) Dental services 1.85;

(C) Mental or behavioral health services 0.8;

(D) Vision services 2.3;

(E) Speech pathology and audiology services 1.8; and

(F) Physical medicine services 2.0.

(iii) Any adjustment is to be computed on an annualized base of thirty hours per week and does not exceed one hundred per cent.